Amendment 82-7
T. L. 82-7
June 28, 1982

STATE PLAN FOR MEDICAL ASSISTANCE UNDER TITLE XIX

Attachment 3.1-C

STANDARDS AND METHODS OF ASSURING HIGH QUALITY CARE

The Medical Assistance Bureau has in operation several separate, but interrelated methods of assuring high quality care. These methods include: review of acute care, long term care and ambulatory care by the New Mexico Professional Standards Review Organization (NMPSRO); drug program monitoring through the Department, operation of the Surveillance and Utilization Review subsystem and the Medical Management Program for recipients; Department monitoring of the NMPSRO review activities; and special provisions relating to quality of care in IHS hospitals.

PSRO operations are discussed in the following Part I; Department operations are discussed under Part II.

PART I - NMPSRO REVIEW FUNCTION

NMPSRO provides utilization review of services to acute care patients and long term care patients through contracts with the Department of Human Services. These activities are described below in Sections A and B. NMPSRO also provides utilization review of services to ambulatory patients through a direct contract with the Department. The specifics of each area of care are described below in Section C.

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DATE APPV'D 8/24/82
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Amendment 86-05
T. L. 86-05
April 1, 1986

A. REVIEW OF HOSPITAL ADMISSION

I. INTRODUCTION

The New Mexico Medical Assistance Program (MAP) has directed its review efforts to ensure compliance with the Medicaid program's objectives for cost containment and quality control. The NMMRA, acting under contract to the MAP, will perform medical review under the Medicaid system to ensure that:

1. Admissions to acute care hospitals and medically necessary.

2. All hospital services and surgical procedures provided were appropriate to the patient's condition and were reasonable and necessary to the care of the patient.

3. Patterns of inappropriate admissions and transfers are identified and are corrected. Reimbursement will not be allowed for inappropriate admissions or transfers.

4. The new method of payment and its application by hospitals have not jeopardized quality of patient care.

5. All cases which require a medical peer review decision regarding appropriate utilization of hospital resources, quality of care, or appropriateness of admission, transfer into a different hospital, and readmission, will be reviewed by a NMMRA Physician Consultant or will be reviewed by the NMMRA Medical Director.

II. CRITERIA FOR REVIEW

The NMMRA has developed and the MAP has approved the Acute Level of Care Criteria (ALOCC) and Specialty Criteria for the procedures under medical review in NMMRA's Preadmission Review Program. The criteria are utilization screening tools for use by NMMRA's professional nursing staff.

In the event that these criteria are modified the hospitals will be notified of such modifications including the effective date of implementation.

III. PREADMISSION REVIEW

The NMMRA will perform preadmission review for 100% of those surgical procedures as described in 310.020302 which are proposed as inpatient hospital admissions and all proposed rehabilitation admissions. The preadmission review procedures require that the attending physician's office or the admitting hospital make a request by telephone to the NMMRA for elective surgical procedures prior to the admission. Any such request which is not received for a review determination by the NMMRA prior to the surgery will be subject to retrospective review, denial, and recoupment proceedings, should denial occur.

The NMMRA will utilize Health Service Reviewers and Physician Consultants by appropriate specialty for reviewing elective procedures proposed as inpatient admissions. Any proposed patient admission which fails the criteria will be referred to a Physician Consultant appointed by the NMMRA Medical Director for a determination of medical necessity.

In the event the admission and/or proposed procedures are pending denial, the attending physician and hospital will be contacted by telephone. Should a denial occur, both the physician and the hospital will be notified by NMMRA. It is the responsibility of the attending physician to notify the patient. Should a denial occur, the attending physician and/or patient will have the right to a reconsideration hearing.

IV. CONCURRENT ADMISSION AND CONTINUED STAY REVIEW

The NMMRA will perform concurrent admission and continued stay review for all admissions to specialty hospitals and specialty units within hospitals.

V. RETROSPECTIVE REVIEW

The NMMRA will perform retrospective review on certain types of inpatient cases. Cases will be reviewed on-site at the hospital or in-house for both PDO (reimbursed per discharge) and Non-PDO (reimbursed per TEFRA) hospitals (excluding specialty hospitals and specialty units) based on the volume of cases identified by the Fiscal Agent. On-site review can be expected when the number of cases exceed one hundred (100) per quarter; or, when the NMMRA is in the area for other review reasons. The NMMRA may also perform review at the NMMRA using copies of charts mailed to the NMMRA.

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VI. REVIEW OF INTER-HOSPITAL TRANSFERS AND READMISSIONS

A. Review of Inter-Hospital Transfers

The NMMRA will perform prepayment review of all Medicaid discharges resulting in a transfer to another acute care hospital. The NMMRA will review the medical records, either on-site or in-house, and make a determination regarding the medical necessity and appropriateness of the transfer. If the NMMRA determines non-medical necessity, the NMMRA will institute the denial procedure. The hospital inappropriately transferring the patient will be the hospital subjected to the denial of payment. The receiving hospital will be held harmless.

B. Review of Readmissions Within Seven (7) Calendar Days of Discharge From An Acute Care Facility

The NMMRA will perform prepayment review on Fiscal Agent identified admissions which have occurred within seven (7) calendar days of discharge from an acute care facility. Neither the day of discharge, nor the day of admission is counted when determining whether a (re)admission has occurred.

1. When the admissions are for patently different diagnoses (unrelated reasons), the NMMRA follows the standard that no medical record review is required.

2. If the admissions appear to be related, NMMRA will perform medical review.

3. If the admissions are found to be medically necessary and appropriate, no further action will be taken.

4. If either or both admissions are found to be medically unnecessary, denial will follow.

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VII. REVIEW FOR DIAGNOSIS VERIFICATION AND MEDICAL NECESSITY OF THE ADMISSION

A. The MAP and NMMRA will define the sample size for PDO and Non-PDO hospitals and method of selection for those cases to be subjected to diagnosis verification and medical necessity review.

B. If medical necessity criteria for admission are not met, the HSR will refer the case to a Physician Consultant (PC) by appropriate specialty for a determination of approval or denial of the admission.

C. If the admission is approved, the HSR will perform diagnosis verification by review of the discharge summary and complete the appropriate portion of the worksheet.

D. If the admission is denied by the PC, the HSR will complete the appropriate portion of the review worksheet and initiate a medical necessity denial. No further review is required by NMMRA. The reconsideration process is then available.

VIII. EXAMPLES OF MEDICAID NON-COVERED SERVICES THAT CAN RESULT IN TECHNICAL DENIALS

A. Private duty nursing.

B. Custodial care.

C. Surgery for solely cosmetic reasons.

D. Any hospitalization solely for administration of a drug or biological which is not reasonable or necessary (not safe and effective by FDA), including investigational drugs.

E. Hospitalization for procedures excluded from Medicaid coverage.

F. If the patient reaches a Skilled Nursing or Intermediate Level of Care the hospital stay will no longer be covered by the Medicaid inpatient program.

G. Hospitalization for a person who is hospitalized as part of a workman's compensation claim or a person who is hospitalized as part of a liability claim.

IX. RECONSIDERATIONS

If a recipient or recipient's next of kin or personal representative or attending physician or hospital is dissatisfied with a NMMRA medical review determination, that party may request a reconsideration. If the patient has been discharged, this request must be made within sixty (60) days of receipt of the contested determination or if more than sixty days have elapsed the requesting party must submit documentation of extenuating circumstances for late filing. The request for reconsideration shall be made in writing to the NMMRA Medical Director and must identify for what part of the determination a reconsideration is being requested.

On receiving such a request, the NMMRA Medical Director shall notify all potential parties of the reconsideration and shall conduct reconsideration hearing(s) with a panel of Physician Consultants by appropriate specialty, at a time convenient for all parties within ten (10) working days of receiving the request. The panel shall consist of NMMRA Physician Consultants who have no previous association with the case and who are at least equal in expertise to that of the attending physician.

If the patient is still an inpatient when the reconsideration is requested, the hospital is required to contact the NMMRA for a review determination by telephone request. The NMMRA will make its reconsideration determination and provide verbal notice with follow-up written notice to the parties within one (1) working day after it receives the verbal request for reconsideration.

If the patient is no longer an inpatient when reconsideration is requested, the NMMRA will make its reconsideration determination and provide written notice to the parties within ten (10) working days after it receives the request for reconsideration and all necessary documents for review. In reconsidering the original determination, the NMMRA shall review the evidence and findings upon which such determination was based and any additional evidence submitted to or otherwise obtained by the Committee. A reconsideration hearing is not an adversary process.

The NMMRA Medical Director and panel of Physician Consultants shall use at least the following information for a reconsideration:

1. The records which were submitted to the panel initially when the attending physician or practitioner proposed to provide services.

2. The findings which led to the adverse initial determination.

3. The complete record of the hospital stay of the patient.

4. Any additional documentary information submitted by the party with its request for reconsideration.

5. Any oral presentation which the appealing party or its authorized representative may choose to present to the Committee.

The NMMRA shall make a reconsideration determination affirming, modifying, or reversing the initial adverse determination.

The reconsideration determination shall be final and binding upon all parties to the determination unless a request is made for a hearing to be conducted by the Human Services Department. In order to preserve a record for possible appeal to the Human Services Department, or possible judicial review, the NMMRA shall document and preserve a record of the reconsideration determination for a period of one year following the date of the reconsideration hearing. This record shall include all documentation of the adverse initial determination, the complete record of the hospital stay of the patient, any additional evidence presented by the appealing party, and a copy of the notice of reconsideration determination.

A party requesting a reconsideration may decide the withdraw the request by submitting a written withdrawal statement to the NMMRA Medical Director.

X. QUALITY ASSURANCE REVIEW

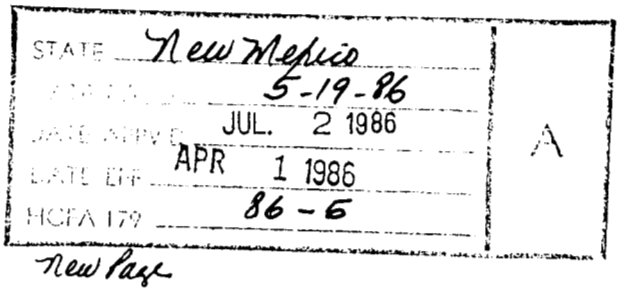
All cases reviewed for any reason by Physician Consultants and the Medical Director of NMMRA, will also be reviewed to assure that the patients received services and treatment appropriate to the condition being treated and were not discharged prematurely. A worksheet will be completed and maintained by the NMMRA for each case reviewed for quality of care.

Any case which fails quality screens or physician standards of care will be referred by NMMRA's Medical Director in writing to the Hospital Chief of Staff or Chairperson of Quality Assurance Review for follow through. In the event that an aberrant pattern is identified, the NMMRA will require that the hospital initiate appropriate action to correct the pattern.

NMMRA's Medical Director will monitor the hospital's progress for assuring quality of patient care in the event that such cases are identified as described above.

XI. DISCHARGE PLANNING

Discharges should be coordinated with utilization review efforts and should never be delayed because post-hospital planning has been neglected. Upon request, the County Income Support Division or Social Services Division caseworker handling the case will assist the hospital's social service department in arranging for the most appropriate post-hospital care for the recipient.



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B. REVIEW OF CARE PROVIDED TO RECIPIENTS ADMITTED TO LONG TERM CARE FACILITIES

I. INTRODUCTION

As a result of the loss of Federal funding for binding review of Long Term Care under Title XI on September 30, 1981, the responsibility for assuring that UR/UC review is carried out in Long Term Care facilities was shifted to the Human Services Department.

The Department has elected to contract with the NMPSRO to carry out the Long Term Care review function. The NMPSRO will carry out this function according to the New Mexico Plan for Long Term Care Review which is set forth in this document.

The Department has received a superior performance waiver for this review process because it deviates from the requirements of Section 1861 (k) of the Social Security Act, but has been determined to be a superior review procedure by the Health Care Financing Administration as allowed under Section 1903 (i) (4) of the Act.

II. GENERAL INFORMATION

The N.M. Plan for Long Term Care Review will consist of two basic elements.

1. Level of Care/Length of Stay Determinations
2. On-Site PMR/IPR Review

The level of care/length of stay determinations will be carried out using a combination of in-house abstract review and on-site review. All determinations will be made according to the criteria and guidelines set forth in this plan.

The on-site PMR/IPR review will be carried out using a modified method of the Title XIX regulations.

III. LOC/LOS REVIEW

The LOC/LOS review will be carried out by PSRO staff. This staff consists of Review Coordinators, who are RNs, and physician reviewers.

Medical information supplied by the LTC facility, the attending physician, and/or information gathered on-site by the review coordinator will be utilized in rendering level of care/length of stay determinations.

A. Criteria

An established set of medical criteria will be used in rendering level of care determinations. The Level of Care Criteria has been adopted for screening review and was developed by New Mexico physicians for use in determining need for services which are usually delivered in either skilled or intermediate care facilities. These criteria have been approved and in use since February, 1979. These are screening criteria which are specifically utilized by the Review Coordinators for all LTC admission, re-admission, and continued stay assessment reviews.

If screens are met and the Review Coordinator is satisfied that the recipient's condition justifies the level of care requested, the admission, re-admission, or continued stay review is determined as medically necessary and a level of crae and length of stay is assigned.

If the Review Coordinator has some doubt that the screens are met or that the level of care request is appropriate, i.e., the recipient appears to require a higher or lower level of care than that requested, the Review Coordinator will refer the case to a Physician Reviewer for a determination. The Physician Reviewer is not strictly bound by the Level of Care Criteria because his/her own expertise and medical judgement will be utilized and is encouraged as part of the peer review concept.

An exception to this will be made in the case of continued stay recertification review on a recipient who does not clearly meet the screens, but whose condition has remained the same since the last review. Rather than referring this case to a Physician Reviewer, the Review Coordinator may reassign the level of care determined by the Physician Reviewer at the time of the last review. This exception will only be utilized in those cases where the recipient's condition has clearly remained stable and no new medical need has developed.

LEVELS OF CARE

In order to justify stay at a SN level of care, a resident must require skilled nursing services (listed on the following pages)

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on a daily basis. The need for a single skilled service on an occasional basis would not justify, by itself, a skilled level of care. In determining the level of care, therefore, consideration must be given to:

1. The level of services required.

2. The frequency with which they are required.

Criteria are predetermined indicators against which aspects of actual care can be compared to judge their necessity for services. The following criteria lists types of care and services that are often appropriate in a skilled or non-skilled LTC facility. The criteria indicate the level of care recommended for residents who require any of the listed services routinely. If a service justifies the skilled level in certain circumstances and the non-skilled services are such that they can only be accomplished in a SNF, through skilled management or observation, assignment of a skilled level of care is appropriate. (See Criterion 9.)

SKILLED LEVEL OF CARE

An individual requires a skilled level of services if she/he needs: (1) on a daily basis, (2) skilled nursing care or other skilled rehabilitation services, and (3) such services can be provided only in a skilled nursing facility on an inpatient basis. The patient's medical record must clearly show that all three factors are met and continue to be met.

A. Daily Skilled Services -- Skilled nursing services or skilled rehabilitation services must be required and provided on a "daily basis" -- i.e., on essentially a 7-day-a-week basis. A break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical would not violate the requirement.

B. Skilled Services Defined -- A skilled service is one which must be furnished by or under the general supervision of skilled personnel to assure the safety of the patient and achieve the medically desired result.

C. Skilled Nursing Services Defined -- A skilled nursing service is one which must be furnished by or under the general supervision of licensed nursing personnel and under the general direction of a physician to assure the safety of the patient and achieve the medically desired result.

D. Need Satisfied Only by SNF Inpatient Care -- In determining whether the care needed can only be provided in a skilled nursing facility on an inpatient basis, consideration must be given to the patient's condition and to the availability